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CONNECTICUT HEALTH INSURANCE BENEFIT REVIEWS

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ISSUE

Explain health insurance benefit reviews.

Benefit/Utilization Review

In general, utilization reviews evaluate criteria such as a medical service's necessity, quality, appropriateness, efficacy, and setting (e.g., whether the service is delivered in a hospital or clinic).

Although commonly known as a benefit review, the legal term for this process is "utilization review." This review is one factor used to determine if a specific medical service is reimbursable by the individual's health plan.

SUMMARY

Utilization (or benefit) review is the process health carriers (e.g., insurers) and independent review organizations use to determine whether a medical service is medically necessary, appropriate, effective, or efficient (CGS § 38a-591a(39)).

In general, there are three types of utilization reviews:

1. prospective, which is conducted before the delivery of a medical service or course of treatment;
2. concurrent, which is conducted while a medical service or course of treatment is being provided; and
3. retrospective, which is conducted after a requested medical service or course of treatment is provided.

Reviews are also categorized as urgent or non-urgent based on the covered person's medical condition. Urgent reviews, also called expedited reviews, must be completed more quickly than non-urgent reviews.

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REVIEW PROCESS AND REVIEW REQUESTS

Reviews may be initiated by the covered person (e.g., insured, enrollee, or member) or his or her authorized representative or the covered person's health carrier.

A medical service or course of treatment may be reviewed up to three times, as follows:

1. an initial review, to determine if the procedure is covered;
2. a grievance review, which occurs when a covered person appeals a benefit denial (i.e., adverse determination); and
3. an external review, which happens when a covered person exhausts a health carrier's internal process and appeals the carrier's adverse determination to the Connecticut Insurance Department.

Carriers must provide covered persons with a description of their review process, including any material or information they must submit with a request.

INITIAL UTILIZATION REVIEWS

Prospective and Concurrent Reviews of Non-Urgent Care

By law, health carriers must make determinations on prospective and concurrent reviews of non-urgent care requests within a reasonable period of time appropriate to the covered person's medical condition, but within 15 days after receiving a complete review request (CGS § 38a-591d(b)(1)(A)). They may extend this period once, by up to 15 days, under certain conditions (CGS § 38a-591d(b)(1)(B)(3)).

Retrospective Reviews of Non-Urgent Care

Retrospective reviews of non-urgent medical services must be completed within a reasonable period of time and within 30 days after receiving a complete review request (CGS § 38a-591d(b)(1)((B)(2)). Carriers may extend this period once, by up to 15 days, under certain conditions.

Urgent Care Reviews

Health carriers must complete reviews of urgent care requests (regardless of whether the request is prospective or concurrent) as soon as possible, taking into account the covered person's medical condition, and within 72 hours after receiving a complete request. For certain substance use disorders and mental disorders, the reviews must be completed within 24 hours after receiving a complete request (CGS § 38a-591d(c)).

Concurrent reviews must be requested at least 24 hours before the end of a current course of treatment. Carriers may take additional time to complete reviews if they require, and request, more information from the covered person.

GRIEVANCE REVIEWS

A grievance (or internal) review is generally a second utilization review that occurs when a covered person appeals an adverse determination.

An appeal of an adverse determination is conducted by independent clinical peers (e.g., doctors who have experience with the medical services being reviewed) (CGS § 38a-591e(c)(1)(A)).

Many adverse determinations and grievance reviews are based, at least in part, on medical necessity.

Prospective and Concurrent Reviews Based on Medical Necessity

Health carriers must make determinations and notify insureds about prospective and concurrent reviews of non-urgent care requests within a reasonable period of time appropriate to the insured's condition, but within 30 days after receiving the request (CGS § 38a-591e(d)(1)(A)).

Prospective and Concurrent Reviews of Urgent Care Based on Medical Necessity

Carriers must complete urgent care review requests within 72 hours after receiving the request. For certain substance use and mental disorders, carriers must complete reviews within 24 hours after receiving a complete request (CGS § 38a-591e(d)).

By law, carriers must comply with these time frames even if they do not have all the necessary information (CGS § 38a-591e(d)(1)(D)(2)).

Retrospective Reviews

Carriers must complete retrospective reviews of non-urgent medical services within a reasonable period of time appropriate to the covered person's condition and within 60 days after receiving the request (CGS § 38a-591e(d)(1)(B)).

MEDICAL NECESSITY

Reviews may be based in part on whether the medical procedure is "medically necessary."

In general, medically necessary means health care services that a physician, exercising prudent judgment, would provide and that are:

1. in accordance with generally accepted medical standards;

2. clinically appropriate and effective;

3. not primarily for the convenience of the patient, physician, or health care provider; and

4. not more costly than therapeutically equivalent alternative treatments (CGS §§ 38a-513c & 38a-482a).

Grievance Reviews Based on Criteria other than Medical Necessity

Carriers have a longer time to complete reviews of medical services that are denied for reasons unrelated to medical necessity.

If an insured appeals an adverse determination decision that was not based on medical necessity, carriers must complete the review within 20 days after receiving the review request. A carrier unable to meet this time frame due to circumstances beyond its control, may extend the deadline by 10 days. In such a case, it must notify the covered person or his or her authorized representative of the extension and the reasons for the delay (CGS § 38a-591f(c)).

EXTERNAL REVIEWS

In certain circumstances, including when a health carrier's internal review process is exhausted, a covered person or his or her authorized representative may request that an independent review organization (IRO) conduct an external review of the adverse determination.

Requests for external reviews must be made in writing to the insurance commissioner and must include a $25 filing fee unless the covered person is indigent or unable to pay.

Generally, a covered person must complete a carrier's internal review process and receive what's known as a "final adverse determination" or "final determination" before filing for an external review. However (1) a carrier may waive the internal grievance process or (2) a covered person may skip a carrier's internal review process under certain circumstances, including if the time period for completing a review would jeopardize his or her health or ability to regain maximum function (CGS § 38a-591g(b)(1)).

Once a request for an external review is filed, the carrier determines whether the covered person is eligible for an external review and notifies the commissioner. If the individual is eligible, the commissioner assigns an IRO to conduct the review.

IROs must complete reviews within 45 days after receiving the assignment from the commissioner, unless the medical service:

1. is experimental or investigational, in which case the review must be completed within 20 days;
2. is experimental or investigational and the request is expedited, in which case the review must be completed within five days;

3. requires an expedited review, in which case the review must be completed as expeditiously as the covered person's medical condition requires and within 72 hours; or

4. is treatment for certain substance use disorders or co-occurring or certain other mental disorders, in which case the review must be completed within 24 hours.

An IRO may uphold, reverse, or revise the carrier's adverse determination (CGS § 38a-591g(i)).

URGENT CARE

In general, a medical service is urgent if the time period for making a non-urgent request:

1. could seriously jeopardize the life or health of the covered person or his or her ability to regain maximum function or

2. would, in the opinion of a health care professional with knowledge of the covered person's medical condition, subject the covered person to severe pain that cannot be otherwise adequately managed without the requested treatment or service (CGS § 38a-591a(38)).

By law, the following medical issues are also considered urgent: certain substance use disorders, co-occurring mental disorders, and mental disorders requiring (1) inpatient services, (2) partial hospitalization, (3) residential treatment, or (4) intensive outpatient services necessary to avoid inpatient treatment (CGS § 38a-591a(38)).

Other medical services may be considered urgent under certain conditions. For example, in determining whether a request is urgent during an initial review, an individual acting on behalf of a health carrier must apply the judgement of a prudent lay-person who possesses an average knowledge of health and medicine (CGS § 38a-591d(a)(2)).

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